Written Statement Submitted to
House Ways and Means Subcommittee on Human Resources

Regarding the October 27, 2011, Hearing:
Supplemental Security Income Benefits for Children
with Low-Income and Severe Mental and/or Physical Disabilities

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Ave
Washington, D.C. 20016
202-966-7300 x108
202-966-1944 (fax)
Kkroeger@aacap.org

Mr Chairman and Members of the Committee:

The American Academy of Child and Adolescent Psychiatry (AACAP) is a medical membership association established by child and adolescent psychiatrists in 1953. Now over 8,000 members strong, AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7-12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders.

I would like to thank the committee for holding this important hearing. Supplemental Security Income (SSI) is a crucial benefit for 1.2 million American children with marked and severe functional limitations. This monthly benefit has provided countless American families with the ability to get their child the treatment they need to become productive members of society who no longer rely on public assistance. All Americans have a vested interest in ensuring the continued success of this program.

Growth of the SSI Program

There has been concern regarding the rate of growth within the SSI program over the last decade, a closer examination of the demographic trends shows that the relative growth in the program has been modest. In the last decade, there has been a 4% increase in child population growth, couple this with a 41% increase in child poverty and the majority of the growth in the SSI program is accounted for.[1] Of all children in America, only 1.6% receives SSI disability support, which equals about 1/10 of children with disabilities across the country.[2] A majority of children who apply for SSI benefits continue to be turned down, a trend that has been stable throughout the last decade. [3]

[1] U.S Census Bureau. "Historical Poverty Tables – People: Table 3." Last accessed October 21, 2011: http://www.census.gov/hhes/www/poverty/data/historical/hstpov3.xls

[2] Social Security Administration, Annual Statistical Report on The Supplemental Security Income Program, 2009

[3] U.S. Government Accountability Office, Supplemental Security Income Preliminary Observation on Children with Mental Impairments 2011

SSI and Psychotropic Medications

There has been great concern that psychotropic medications are being prescribed to children to increase their chances of being approved for SSI benefits. This claim was promoted by a series of articles in the Boston Globe in December of 2010. This claim has been disproven by numerous studies. A recent GAO report cited numerous disability determinations services (DDS) offices who said,

> "that when making determinations for children with mental impairments, medication is considered in the context of other sources of information as just one piece of the puzzle. To the extent that medication improves functions some DDS officials told us they could potentially find that the child is not disabled under program rules. Despite this fact… some parents are under the impression that medicating their children will improve their likelihood of being found eligible for benefits."[4]

As the above GAO report shows, the addition of psychotropic medications does not increase a child's chance of being approved for SSI benefits. Treating a child with medication may reduce their chance of being approved for SSI benefits. As any functional improvement that the medication assists with must be taken into account when determining the eligibility for SSI benefits.

Safeguards Against Corruption

The SSI program has significant safeguards in place to protect the program's integrity and an exemplary performance accountability review (PAR) rate. Prior to receiving SSI benefits, a child must have a medically determinable physical or mental impairment or combination of impairments that result in marked and severe functional limitations. This is determined by first obtaining information from the claimant's treating physician. In the case of a child with mental illness, this physician is often a child and adolescent psychiatrist. The treating source submits reports about the child's impairments including the child's:

- medical history,
- clinical findings,
- laboratory findings,
- diagnosis,
- treatment prescribed with response and prognosis of treatment , and
- a statement providing an option about what the claimant can still do despite their impairment(s).

For a child with mental impairments, the statement should describe the child's ability to function independently, appropriately, and in the functional criteria appropriate for the child's age. The treating source in not asked or expected to make a decision on whether the child is disabled. Additional information is received from health care providers, school professionals and other adults caring for the child and includes assessments of the child's functioning in home, school and the community setting over time. The information compiled from the claimant's treatment sources and other information provided by the parents or school system is then evaluated by the DDS. This evaluation is made by a two-person adjudicative team consisting of a medical or psychological consultant and a disability examiner. A comprehensive psychiatric evaluation usually requires several hours to complete and is best performed over multiple sessions.

[4] Ibid.

In addition to the review process stated above, the Social Security Office of Quality Performance monitors accuracy of initial determination and reports over a 97% net accuracy rate for fiscal year 2009.[5]

In conclusion, the SSI program is a crucial program that helps over 1.2 million poor children with marked and severe functional limitations. While the program itself has been growing in the last decade, the growth is consistent with overall demographic changes (more children and a significant increase in child poverty.) Claims that children are put on psychotropic medications to increase their chances of being accepted into the SSI program do not hold up upon closer examination. The use of medication may even reduce a child's chance of being approved for SSI benefits as any functional improvements that the medication leads to must be taken into account when determining the child's eligibility for SSI benefits. Claims of widespread corruption in the SSI program are also incorrect. However, AACAP recognizes that the SSI program needs to increase the number of continuing disability reviews (CDR) to ensure that children who are no longer eligible for benefits do not continue to receive them. The SSI Office of Quality Performance determined that the SSI program has a 97% net accuracy rate in its initial determinations. We applaud the Congress and the Administration for increasing funding for crucial safeguard mechanisms.

We ask the committee not to rush to make changes to this vital program. Unfounded accusations should not determine the future of the SSI program. Any improvements made to this program should be evidence-based and ensure that we strengthen and not weaken the SSI program. AACAP thanks the committee for their oversight of this vital program.

[5] Social Security Administration, *Annual Report to Congress of Continuing Disability Review for FY 2009*

Supplemental Contact Information

Organization: The American Academy of Child and Adolescent Psychiatry

Address: 3615 Wisconsin Avenue, NW Washington DC 20016

Contact: Kristin Kroeger Ptakowski

Contact's Phone Number: (202) 966-7300

Contact's E-mail address: kkroeger@aacap.org